

		FOR OHF USE					

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2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: 0038620</p> <p>Facility Name: HERITAGE NURSING HOME</p> <p>Address: 5888 N. RIDGE AVENUE CHICAGO 60660 Number City Zip Code</p> <p>County: COOK</p> <p>Telephone Number: (773) 769-2626 Fax # (773) 769-2650</p> <p>IDPA ID Number: 363853045001</p> <p>Date of Initial License for Current Owners: 11/01/92</p> <p>Type of Ownership:</p> <table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other</td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236 - 1111</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed)</td></tr><tr><td>(Type or Print Name)</td></tr><tr><td>(Title)</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) See Accountants' Compilation Report Attached</td></tr><tr><td>(Date)</td></tr><tr><td>(Print Name and Title) DONALD MAGNUSON, C.P.A.</td></tr><tr><td>(Firm Name &amp; Address) Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</td></tr><tr><td>(Telephone) (847) 236-1111 Fax # (847) 236-1155</td></tr></table> <p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed)	(Type or Print Name)	(Title)	Paid Preparer	(Signed) See Accountants' Compilation Report Attached	(Date)	(Print Name and Title) DONALD MAGNUSON, C.P.A.	(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015	(Telephone) (847) 236-1111 Fax # (847) 236-1155
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME

# 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>NA</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>44</u>	Skilled (SNF)	<u>44</u>	<u>16,060</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>84</u>	Intermediate (ICF)	<u>84</u>	<u>30,660</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>128</u>	TOTALS	<u>128</u>	<u>46,720</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,307</u>	<u>364</u>	<u>980</u>	<u>7,651</u>	8
9	SNF/PED					9
10	ICF	<u>29,323</u>	<u>47</u>		<u>29,370</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,630</u>	<u>411</u>	<u>980</u>	<u>37,021</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.24%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?  
202 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 07/01/82

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 07/01/82 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 21 and days of care provided 575

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	149,434	18,270	4,718	172,422		172,422		172,422		1
2	Food Purchase		189,227		189,227	(33,215)	156,012	(21)	155,991		2
3	Housekeeping	96,307	13,916		110,223		110,223		110,223		3
4	Laundry	48,373	11,494		59,867		59,867		59,867		4
5	Heat and Other Utilities			83,478	83,478		83,478		83,478		5
6	Maintenance	48,025		53,141	101,166		101,166	(25,121)	76,045		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	342,139	232,907	141,337	716,383	(33,215)	683,168	(25,142)	658,026		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,400	7,400		7,400		7,400		9
10	Nursing and Medical Records	1,097,821	41,271	39,573	1,178,665		1,178,665		1,178,665		10
10a	Therapy	55,766		4,395	60,161		60,161		60,161		10a
11	Activities	56,901	3,009	4,459	64,369		64,369		64,369		11
12	Social Services	47,029	225	4,826	52,080		52,080		52,080		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,257,517	44,505	60,653	1,362,675		1,362,675		1,362,675		16
	<b>C. General Administration</b>										
17	Administrative	93,433		266,056	359,489		359,489	5,784	365,273		17
18	Directors Fees										18
19	Professional Services			59,787	59,787		59,787	(16,324)	43,463		19
20	Dues, Fees, Subscriptions & Promotions			13,939	13,939		13,939	(2,227)	11,712		20
21	Clerical & General Office Expenses	74,898		288,459	363,357		363,357	(223,451)	139,906		21
22	Employee Benefits & Payroll Taxes			308,314	308,314	33,215	341,529	(9,000)	332,529		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,525	1,525		1,525		1,525		24
25	Other Admin. Staff Transportation			1,221	1,221		1,221		1,221		25
26	Insurance-Prop.Liab.Malpractice			92,100	92,100		92,100		92,100		26
27	Other (specify):*							474	474		27
28	<b>TOTAL General Administration</b>	168,331		1,031,401	1,199,732	33,215	1,232,947	(244,744)	988,203		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,767,987	277,412	1,233,391	3,278,790		3,278,790	(269,886)	3,008,904		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			55,967	55,967		55,967	53,228	109,195			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,042	13,042		13,042	86,387	99,429			32
33	Real Estate Taxes							145,776	145,776			33
34	Rent-Facility & Grounds			507,856	507,856		507,856	(507,856)				34
35	Rent-Equipment & Vehicles			382	382		382		382			35
36	Other (specify):*											36
37	TOTAL Ownership			577,247	577,247		577,247	(222,465)	354,782			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,990	21,227	30,217		30,217		30,217			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,080	70,080		70,080		70,080			42
43	Other (specify):*	67,600		21,565	89,165		89,165	(89,165)				43
44	TOTAL Special Cost Centers	67,600	8,990	112,872	189,462		189,462	(89,165)	100,297			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,835,587	286,402	1,923,510	4,045,499		4,045,499	(581,516)	3,463,983			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,687)	30		9
10	Interest and Other Investment Income	(1,272)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(445)	21		18
19	Entertainment	(4,028)	21		19
20	Contributions	(6,070)	21		20
21	Owner or Key-Man Insurance	(9,000)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(196,000)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(154,789)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (379,312)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(202,204)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (202,204)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (581,516)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
HERITAGE NURSING HOME		
ID#	0038628	
Report Period Beginning:	01/01/02	
Ending:	12/31/02	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 BANK CHARGES	(4,117)	21 1
2 RESIDENT EXPENSES	(1,792)	21 2
3 OTHER - NON-ALLOW	(962)	21 3
4 MARKETING EXPENSES	(19,893)	43 4
5 GAIN/LOSS ON SALE OF FIXED ASSETS	(4,800)	21 5
6 MISC. INCOME	(419)	21 6
7 COPE - IL COUNCIL LTC	(2,227)	20 7
8 PROFESS.FEES/MARKETING	(16,200)	19 8
9 BLDG- ACCOUNTING FEES	(3,000)	19 9
10 LEGAL - NON-ALLOW PY	(117)	19 10
11 MARKETING SALARIES	(67,600)	43 11
12 NON-CARE ASSET (AUTO)	(3,844)	40 12
13 AUTO EXP. FOR MARKETING	(1,672)	43 13
14 R&M CAPITALIZED	(25,121)	06 14
15 PY EXPENSES	(4,739)	21 15
16		16
17		17
18		18
19		19
20		20
21		21
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25		25
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90		90
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92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(154,789)	101

## Summary A

12/31/02

[illegible]

## Summary B

12/31/02

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		PRO HEALTH	BUFFALO GROVE	MANAGEMENT
				HERITAGE H.C.	CHICAGO	BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 362,080	HERITAGE HEALTH CARE CENTER	100.00%	\$	\$ (362,080)	1
2	V	34	RENT-R.E. TAXES	145,776	HERITAGE HEALTH CARE CENTER	100.00%		(145,776)	2
3	V	19	ACCOUNTING FEES		HERITAGE HEALTH CARE CENTER	100.00%	2,000	2,000	3
4	V	33	R.E. TAXES		HERITAGE HEALTH CARE CENTER	100.00%	146,329	146,329	4
5	V	33	R.E. TAXES PRIOR YEAR		HERITAGE HEALTH CARE CENTER	100.00%	(553)	(553)	5
6	V	30	DEPRECIATION EXPENSE		HERITAGE HEALTH CARE CENTER	100.00%	63,959	63,959	6
7	V	32	INTEREST EXPENSE		HERITAGE HEALTH CARE CENTER	100.00%	87,659	87,659	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 507,856			\$ 299,394	\$ * (208,462)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	\$	PRO HEALTH CARE, INC.	100.00%	\$ 11,329	\$ 11,329	15
16	V	27	PAYROLL TAXES		PRO HEALTH CARE, INC.	100.00%	474	474	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MANAGEMENT FEES	5,545				(5,545)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 5,545			\$ 11,803	\$ * 6,258	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STAN ARON	Owner	Administrative	8.19%	See Attached	3	4.61%	Alloc-Pro HC	\$ 11,329	17-7	1
2	SYLVIA HERLIHY	Administrator	Administrative	None	See Attached	40	66.67%	Salary	63,212	17-1	2
3								Mgmt Fee	25,000	17-3	3
4	DAN SHABAT	Owner	Administrative	20.49%	See Attached	25	41.67%	Salary	30,221	17-1	4
5								Mgmt Fee	235,511	17-3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 365,273		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization PRO HEALTH CARE, INC. C/O FR&R  
Street Address 111 PFINGSTEN ROAD  
City / State / Zip Code DEERFIELD, IL 60115  
Phone Number ( 847)236-1111  
Fax Number ( 847)236-1155

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	Avg. Hours Worked	51	4	\$ 192,600	\$ 192,600	3	\$ 11,329	1
2	27	PAYROLL TAXES	Avg. Hours Worked	51	4	8,057		3	474	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 200,657	\$ 192,600		\$ 11,803	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

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( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HERITAGE NURSING HOME # 0038620 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	SENN PARK MANAGEMENT	X		MORTGAGE	\$20,958.00	12/01/92	\$ 1,952,000	\$ 831,836	12/01/06	9.66%	\$ 87,659	1	
2	LEXUS FINANCIAL SERV.	X		AUTO LOAN	\$677.00	04/02/98	27,245	25,375	04/02/02	8.17%	919	2	
3												3	
4												4	
5												5	
	Working Capital												
6	SHAREHOLDERS LOANS	X		WORKING CAPITAL	None	11/02/92	500,000	500,000		IRS Rate	12,123	6	
7												7	
8												8	
9	TOTAL Facility Related				\$21,635.00		\$ 2,479,245	\$ 1,357,211			\$ 100,701	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule										(1,272)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,272)	14	
15	TOTALS (line 9+line14)						\$ 2,479,245	\$ 1,357,211			\$ 99,429	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME		X				\$	\$			\$ (1,272)	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	\$			\$ (1,272)	21

**SEE ACCOUNTANTS' COMPILATION REPORT**

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

HERITAGE NURSING HOME

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0038620

CONTACT PERSON REGARDING THIS REPORT

STEVE LAVENDA

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

- A. Summary of Real Estate Tax Cost
- Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	14-05-306-016-0000	Long Term Care Property	\$ 142,066.93	\$ 142,066.93
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 142,066.93	\$ 142,066.93

- B. Real Estate Tax Cost Allocations
- Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?           YES      X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)
- C. Tax Bills
- Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

HERITAGE NURSING HOME

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0038620

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( )

FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      YES      NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,400

B. General Construction Type: Exterior BRICKFrame STEELNumber of Stories 3

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1992	\$ 105,600	1
2					2
3	TOTALS			\$ 105,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		22,988		20	1,150	1,150	11,198	9
10	Various		1994		38,610		20	1,931	1,931	14,357	10
11	Various		1995		68,517		20	3,427	3,427	25,387	11
12	Various		1996		107,653		20	5,382	5,382	36,412	12
13	Various		1997		32,071		20	1,757	1,757	10,094	13
14	Various		1998		19,271		20	964	964	4,474	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,130,587	63,959		61,588	(2,371)	831,221	68
69	Financial Statement Depreciation			13,941			(13,941)		69
70	TOTAL (lines 4 thru 69)		\$ 2,419,697	\$ 77,900		\$ 76,199	\$ (1,701)	\$ 933,143	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,470,439	\$ 77,900		\$ 78,738	\$ 838	\$ 940,311	1
2	BOILER ROOM PUMP	2000	725		20	36	36	84	2
3	PUMP/WATER LINE	2001	510		20	26	26	50	3
4	EXHAUST FANS	2001	1,755		20	88	88	147	4
5	COOLING VALVES	2001	610		20	31	31	49	5
6	PIPING/DRAIN	2001	895		20	45	45	68	6
7	ROOFING	2001	725		20	36	36	45	7
8	SINK TRAP & SEWER	2001	525		20	26	26	33	8
9	FRONT DOOR GLASS	2001	1,487		20	74	74	80	9
10	ABSORPTION CHILLERS	2001	4,588		20	229	229	248	10
11	ALARM	2002	11,754		20	980	980	980	11
12	WALLS W/ DOOR	2002	1,600		20	13	13	13	12
13	SLIDING DOORS	2002	7,985		20	399	399	399	13
14	COOLING SYSTEM	2002	3,197		20	160	160	160	14
15	FLOORING	2002	854		20	43	43	43	15
16	HEATING SYSTEM	2002	733		20	37	37	37	16
17	BOILER REPAIR	2002	3,840		20	192	192	192	17
18	COMPRESSOR	2002	557		20	28	28	28	18
19	HEATING SYSTEM	2002	2,129		20	106	106	106	19
20	DOOR HOLDERS SYSTEM	2002	600		20	30	30	30	20
21	WALK IN FREEZER REPAIR	2002	731		20	37	37	37	21
22	COOLING SYSTEM	2002	753		20	38	38	38	22
23	COOLING SYSTEM	2002	2,029		20	101	101	101	23
24	EXHAUST FANS	2002	1,600		20	80	80	80	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,520,621	\$ 77,900		\$ 81,573	\$ 3,673	\$ 943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,520,621	\$77,900		\$81,573	\$3,673	\$943,359	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	128			1991	\$ 1,878,400	\$ 58,901	35	\$ 53,669	\$ (5,232)	\$ 644,028	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HERITAGE HEALCARE CENTER			1992	23,467	408	20	1,174	766	12,212	9
10	HERITAGE HEALCARE CENTER			1991	118,564	3,189	20	5,928	2,739	66,733	10
11	HERITAGE HEALCARE CENTER			1990	4,919	207	20	246	39	3,011	11
12	HERITAGE HEALCARE CENTER			1987	2,250	1,254	20	113	1,141	2,250	12
13	HERITAGE HEALCARE CENTER			1986	5,000		19	263	263	5,000	13
14	HERITAGE HEALCARE CENTER			1985	8,483		15	195	195	8,483	14
15	HERITAGE HEALCARE CENTER			1983	6,069		15			6,069	15
16	HERITAGE HEALCARE CENTER			1981	78,925		5			78,925	16
17	HERITAGE HEALCARE CENTER			1978	4,510		5			4,510	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$2,130,587	\$63,959		\$61,588	\$(89)	\$831,221	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$264,959	\$35,262	\$25,451	\$ (9,811)	10	\$115,469	71
72	Current Year Purchases	1,712		171	171	10	171	72
73	Fully Depreciated Assets	292,198				10	292,198	73
74								74
75	TOTALS	\$558,869	\$35,262	\$25,622	\$ (9,640)		\$407,838	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BUSINESS	JAGUAR	2002	\$30,000	\$3,720	\$2,000	\$ (1,720)	5	\$2,000	76
77										77
78										78
79										79
80	TOTALS			\$30,000	\$3,720	\$2,000	\$ (1,720)		\$2,000	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,215,090	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$116,882	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$109,195	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,687)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,353,197	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	JAGUAR - 2002	\$24,888	\$3,044	\$3,044	86
87					87
88					88
89					89
90					90
91	TOTALS	\$24,888	\$3,044	\$3,044	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 382 Description: Postal Machine - Pitney Bowes

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning  
Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$  
13. /2004 \$  
14. /2005 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building,  
please provide complete details on attached  
schedule.

\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		1		2		3		4	
		Facility		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$							
2	Books and Supplies								
3	Classroom Wages (a)								
4	Clinical Wages (b)								
5	In-House Trainer Wages (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$		\$		\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$							

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 10,260	\$		\$ 10,260	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,170			4,170	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			6,450			6,450	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				3,373		3,373	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					347	5,617		5,964	13
14	TOTAL			\$		\$ 21,227	\$ 8,990		\$ 30,217	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 179,740	\$ 179,740	1
2	Cash-Patient Deposits	42,028	42,028	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,037,351	1,037,351	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,088	26,088	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	17,635	91,592	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,302,842	\$ 1,376,799	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,600	13
14	Buildings, at Historical Cost		1,878,400	14
15	Leasehold Improvements, at Historical Cost	245,035	398,348	15
16	Equipment, at Historical Cost	331,255	607,598	16
17	Accumulated Depreciation (book methods)	(268,132)	(1,322,260)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		1,250	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 308,158	\$ 1,668,936	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,611,000	\$ 3,045,735	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 211,283	\$ 211,283	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,028	42,028	28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	197,257	197,257	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,011	8,011	31
32	Accrued Real Estate Taxes(Sch.IX-B)		146,329	32
33	Accrued Interest Payable		6,695	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Supplemental Schedule	592,184	1,098,838	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,550,763	\$ 2,210,441	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	25,375	25,375	39
40	Mortgage Payable		831,836	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Supplemental Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 25,375	\$ 857,211	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,576,138	\$ 3,067,652	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 34,862	\$ (21,917)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,611,000	\$ 3,045,735	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,444	1
2	Restatements (describe):		2
3	Restatement for GAAP Depreciation	(39,994)	3
4	Restatment for Accumulated Depreciation	77,747	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 53,197	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(18,335)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (18,335)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 34,862	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,970,693	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,970,693	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	43,484	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 43,484	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,373	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,350	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,573	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 11,296	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,272	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,272	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	419	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 419	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,027,164	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	716,383	31
32	Health Care	1,362,675	32
33	General Administration	1,199,732	33
	<b>B. Capital Expense</b>		
34	Ownership	577,247	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	119,382	35
36	Provider Participation Fee	70,080	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,045,499	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(18,335)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (18,335)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number HERITAGE NURSING HOME

# 0038620

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,824	2,240	\$ 77,882	\$ 34.77	1
2	Assistant Director of Nursing	1,961	2,185	50,375	23.05	2
3	Registered Nurses	18,220	22,495	452,883	20.13	3
4	Licensed Practical Nurses	5,728	6,696	112,346	16.78	4
5	Nurse Aides & Orderlies	39,036	45,647	372,565	8.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,979	5,749	55,766	9.70	8
9	Activity Director					9
10	Activity Assistants	5,927	6,612	56,901	8.61	10
11	Social Service Workers	2,734	3,195	47,029	14.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,127	18,272	149,434	8.18	15
16	Dishwashers					16
17	Maintenance Workers	3,092	3,873	48,025	12.40	17
18	Housekeepers	10,830	12,031	96,307	8.00	18
19	Laundry	5,813	6,368	48,373	7.60	19
20	Administrator	1,935	2,080	63,212	30.39	20
21	Assistant Administrator					21
22	Other Administrative	1,222	1,300	30,221	23.25	22
23	Office Manager					23
24	Clerical	6,455	8,117	74,898	9.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,400	2,480	31,770	12.81	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,112	2,522	67,600	26.80	33
34	TOTAL (lines 1 - 33)	130,395	151,862	\$ 1,835,587 *	\$ 12.09	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 4,718	01-03	35
36	Medical Director	Monthly	7,400	09-03	36
37	Medical Records Consultant	Monthly	3,088	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	1	26	10-03	39
40	Physical Therapy Consultant	43	2,077	10a-03	40
41	Occupational Therapy Consultant	48	2,318	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	127	4,459	11-03	44
45	Social Service Consultant	90	4,826	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	309	\$ 28,912		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,042	\$ 36,459	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,042	\$ 36,459		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
SYLVIA HERLIHY	Administrator	0	\$ 63,212	Workers' Compensation Insurance		\$ 25,825	IDPH License Fee	\$	
DANIEL SHABAT	Administrative	20.49%	30,221	Unemployment Compensation Insurance		9,908	Advertising: Employee Recruitment	3,784	
				FICA Taxes		130,785	Health Care Worker Background Check	180	
				Employee Health Insurance		113,409	(Indicate # of checks performed 15 )		
				Employee Meals		33,215	Dues - Ill Council LTC	5,374	
				Illinois Municipal Retirement Fund (IMRF)*			Licenses & Permits	2,374	
				Chicago Head Tax		1,927			
				Pension Contributions		9,230			
				Holiday Expense		8,230			
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 93,433				Non-allowable advertising	( )	
B. Administrative - Other							Yellow page advertising	( )	
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)		
DANIEL SHABAT - MANAGEMENT FEES			\$ 235,511			\$ 332,529	\$ 11,712		
SYLVIA HERLIHY - MANAGEMENT FEES			25,000						
PRO HEALTH - MANAGEMENT FEES			5,545						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 266,056	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)									
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
FR&R	Accounting		\$ 54,297				Out-of-State Travel	\$	
SEE SCHEDULE	Legal		4,935						
PERSONNEL PLANNERS	Unemployment Cslt		555						
							In-State Travel		
							Seminar Expense	1,525	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 59,787				TOTAL	\$ 1,525	

**\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	NA		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		HERITAGE NURSING HOME		STATE OF ILLINOIS				Page 23
		#	0038620	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Nurses Aides

(2)

Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount.

YES  
Ill Council LTC - \$7,521

(3)

Did the nursing home make political contributions or payments to a political action organization?  
If YES, have these costs been properly adjusted out of the cost report?

YES  
YES

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  
If YES, what is the capacity?

NO  
NA

(5)

Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period?

YES  
10 YRS

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 1,012 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?  
If YES, give effective date of lease.

NO  
NA

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES  
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X  
HERITAGE HEALTHCARE CENTER #38620 -11.01.92

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.  
This amount is to be recorded on line 42 of Schedule V.

\$ 70,080

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  
If YES, attach an explanation of the allocation.

NO

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?  
For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.  
Has any meal income been offset against related costs?

\$ 33,215  
N/A  
Indicate the amount. \$ NA

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?  
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?  
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO  
NA

c.

What percent of all travel expense relates to transportation of nurses and patients?

None

d.

Have vehicle usage logs been maintained?

NA

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

NA

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

NA

g.

Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.

NA  
NA

(17)

Has an audit been performed by an independent certified public accounting firm?  
Firm Name:  
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?  
If no, please explain.

NO  
NA  
NA

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  
Attach invoices and a summary of services for all architect and appraisal fees

YES

SEE ACCOUNTANTS' COMPILATION REPORT